Nurses Monthly Summary

Facility Name: _____
Provider Number: _____

Resident's Name: _____ Date: ___/___/___

Resident's ID Number: _____

ADL

ADLS	Needs Help?	
	No 00	Yes
Bathing		
Dressing		
Toileting		
Transferring		
Eating/Feeding		

MH Only 10 Mechanical Help	HH Only 2 D Human Help		MH & HH 3 D		Performed D by Others 40			Is Not D Performed 50
	Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2				
					Spoon Fed 1	Syringe/ Tube Fed 2	Fed by IV 3	

Continence	Needs Help?	
	No 00	Yes
Bowel		
Bladder		

Incontinent Less than Weekly 1	Ext. Device/ Indwelling/ Ostomy Self Care 2	Incontinent D Weekly or More 3	External D Device Not Self Care 4	Indwelling D Catheter Not Self Care 5	Ostomy D Not Self Care 6

Ambulation	Needs Help?	
	No 00	Yes
Walking		
Wheeling		
Stairclimbing		
Mobility		

MH Only 10 Mechanical Help	HH Only 2 D Human Help		MH & HH 3 D		Performed D by Others 40	Is Not D Performed 50
	Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2		
					Confined Moves About	**Confined** Does Not Move About

Personal Assistive Devices Used *(check all correct answers)*

☐ Wheel Chair ☐ Walker ☐ Cane ☐ Bedside Commode
☐ Splint/Braces ☐ Oxygen ☐ Eating Devices ☐ Shower Chair ☐ Hand Rails in Bathroom

Cognitive Status

☐ Oriented
☐ Disoriented – Some spheres, some of the time
☐ Disoriented – Some spheres, all of the time
☐ Disoriented – Some spheres, some of the time
☐ Disoriented – All spheres, all of the time

Memory	**Descriptions for scoring**	**Scores** *(Check correct level)*
Memory Recall: (Score based on the fact the resident **CAN** Remember) (Check all that apply)	1 = Current season 2 = Location of room 3 = Staff faces/names 4 = That they are in ALF 5 = None of the above	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Decision Making Skill: (Score based on the fact the Resident **CAN** make decisions)	1 = Modified independence (difficulty in new situations) 2 = Moderately impaired (decisions are poor, cues supervision is required) 3 = Severely impaired (never/rarely makes decisions)	☐ 1 ☐ 2 ☐ 3
Ability to Communicate using any means: (Score based on the fact the Resident **CAN** communicate)	1 = Initiates communication 2 = Does not initiate communication 3 = Does not understand verbal communication 4 = Does not hear well	☐ 1 ☐ 2 ☐ 3 ☐ 4
Ability to be understood: (Score based on the fact the Resident **CAN** be understood)	1 = Usually understood (difficulty finding words/ thoughts) 2 = Some times understood (ability is limited to concrete requests) 3 = Rarely or never understood	☐ 1 ☐ 2 ☐ 3
Safety Considerations: (Score based on the fact the Resident **CAN** recognize danger)	1 = Recognizes danger 2 = Occasionally will recognize danger 3 = Recognizes danger only if staff point it out 4 = Never recognizes danger	☐ 1 ☐ 2 ☐ 3 ☐ 4

Behavior (check correct column.)

	Daily	Less than weekly	Weekly or more
Appropriate	☐	☐	☐
Wandering/Passive	☐	☐	☐
Wandering/Passive	☐	☐	☐
Abusive/Aggressive/ Disruptive	☐	☐	☐
Abusive/Aggressive/ Disruptive	☐	☐	☐

Elopements (check correct frequency answer) **Elopement is an unauthorized departure from facility**

Attempted Elopements	***Actual Elopement***
☐ none ☐ less than weekly ☐ 2-3 a week ☐ 4-5 a week ☐ daily	☐ none ☐ less than weekly ☐ 2-3 a week ☐ 4-5 a week ☐ daily

Physicians Visits (Include primary and all consulting physicians)

Most recent visit date	Physician's name	Outcome of visit
/ /		
/ /		
/ /		

Current primary diagnosis and new diagnosis:

Physical Condition *(complete each blank with correct answer)*

SKIN CONDITION

_____ # Skin tears Location: _____
_____ # Wounds Location: _____

_____ # Total Ulcers
_____ Stage Location: _____
_____ Stage Location: _____
_____ Stage Location: _____
_____ Stage Location: _____

Dehydration:
Skin Turger test results: ☐ *Good* ☐ *Poor*

Meal Consumption:

Breakfast	Lunch	Dinner
___ %	___ %	___ %

Weight Change:
☐ **Yes** ☐ **No**
Planned:
☐ Yes ☐ No

☐ **Loss** ☐ **Gain**
Amount: ___

HAS PROHIBITING CONDITION:

Dermal Ulcers
Stage 4 # __ Date found: __/__/____
Date healed: __/__/____
Stage 3 # __ Date found: __/__/____
Date healed: __/__/____

Vent Dependency	☐ Yes ☐ No
Intravenous Therapy	☐ Yes ☐ No
Airborne infections	☐ Yes ☐ No
Psy. Meds w/out diagnosis	☐ Yes ☐ No
Nasogastric tubes	☐ Yes ☐ No
Gastric Tube & dependent on feedings	☐ Yes ☐ No
Physician cert inappropriate placement	☐ Yes ☐ No
Meets ADL requirement of Nursing Home w/out Alzheimer's/Dementia Diag.	☐ Yes ☐ No
Resident needs cannot be met by staff	☐ Yes ☐ No

Fecal impaction this month: **Yes** ☐ **No** ☐ ***(If answered yes, describe treatment)***

Treatment provided: _____

Falls: ☐ Yes ☐ No (If answered yes, check frequency of falls)

Check frequency of falls: ☐ less than weekly ☐ 2-3 a week ☐ 4-5 a week ☐ daily

Medication

Current Medications	Continued Medication=Yes or No	New Medications this month =Yes or No	List Adverse Reactions to Medication
	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	

Activities:

Resident's ability to make decisions regarding activities is:

Place score from list below

1 = independently makes decision
2 = occasionally verbalizes desired activity
3 = rarely expresses desired activity
4 = only follows staff lead in selecting activity
5 = is unaware of changes in activities

Time of day resident is most active?

MORNING (6 to 12) ☐
AFTERNOON (12 to 5) ☐
EVENING (5 to 10) ☐
NIGHT (10 to 6) ☐

Average amount of time involved in group activities per week: _____
Average amount of time involved in one on one activity per week: _____
Initiated activities this month: ☐ YES ☐ NO

List favorite activities: _____

_____

_____

Services coordinated this month: (check all services)

Personal Physician ☐	Psychologist Psychiatrist ☐	Day Program ☐	Dialysis ☐	Transportation ☐
Specialist Physician ☐	Home Health Services ☐	Hospice Services ☐	Therapy: OT ☐ PT ☐ SP ☐	

Plan of Care status

Current *Yes* ☐ *No* ☐
Appropriate *Yes* ☐ *No* ☐

Date of most recent review

Administrator Review of Placement: ____ / ____ / ____
Family Review of Placement: ____ / ____ / ____
UAI: ____ / ____ / ____

Completed by: _____ Date: ____ / ____ / ____
Signature and title of nurse

FAX ASSESSMENTS TO:
AAL WAIVER
Division of Long-Term Care & Quality Assurance
Fax number: (804) 786-0206

Instructions for completing the Admissions Assessment / Nurses Monthly Summary Form DMAS -483

* All fields must be completed

1. Enter the facility name.
2. Enter provider number.
3. Enter the resident's full name.
4. Enter the resident's Medicaid ID number.
5. Enter the date of the assessment.
6. ADL assessment: enter a check mark in the correct level of dependency. Use the same definition as used on the UAI to determine functional status.
7. Continence: enter a check mark in the correct level of dependency. Use the same definition as used on the UAI.
8. Ambulation: enter a check mark in the correct level of dependency. Use the same definition as used on the UAI.
9. Enter a check mark in ALL the boxes for the assistive devices the individual has used in the last 30 days.
10. Cognitive Status: check the level that describes the persons level of cognition. Use the same definition as used on the UAI.
11. Memory Recall: place a check mark in the correct number that best describes what the resident can remember.
12. Decision Making Skill: place a check mark in the correct number that best describes what type of decision the resident can make.
13. Ability to Communicate: place a check mark in the correct number that best describes how they communicate most frequently.
14. Ability to Understand: place a check mark in the correct number that best describes how they understand what is communicated.
15. Safety Considerations: place a check mark in the correct number that best describes how they recognize danger.
16. Behavior: column one is checked if the behavior occurs daily. column 2 defines the frequency that the behavior occurs less than weekly. column three is checked if the behavior occurs weekly or more. Use the same definition as used on the UAI.
17. Elopement: list the frequency for attempted and actual occurrences.
18. Physicians Visits: includes all physician visits. List date, physician's name, and the outcome of the visits.
19. Current primary diagnosis and new diagnosis for the recipient: list the primary diagnosis and the diagnosis currently being treated.
20. Physical condition:
    a. List the total number of skin conditions
        i. list the number of skin tears and the location of the tears.
        ii. list the number of wounds and the location of the wounds.
    b. List the total ulcers
        i. list by stage and location (e.g. stage 1 – 3 left arm, right hip and sole of foot).
    c. Dehydration: list the results of the skin turger test as good or poor (No tenting or tenting).
    d. Meal Consumption: list the % of meal consumed for each meal. Use an average for the review period.
    e. Weight Change: check the correct box to signify any weight change exceeding 1 pound during the last 30 days. Check the correct box to signify planned weight loss or gain. Check the correct box as to the type of weight change (loss or gain) and the amount of the weight change.
    f. Fecal Impaction: check the correct box if there was or was not an impaction in the last 30 days. Describe the treatment provided.
    g. Falls: check the correct box as to indicate any falls in the last 30 days. Check the correct box signifying the frequency of the falls.
21. Medication: list all the current medication being taken in column one, or attach a copy of MAR. Indicate if each medication is a continuation from the month prior in column two. Indicate if each medication is a new medication this month in column three. List any adverse reactions that occurred to each medication for the last 30 days in column four. Write none if there are no adverse reactions.
22. Activities: use the key to indicate the number that best describes the resident's ability to make decisions regarding activities.
23. Check the time of day the resident is most active in activities.
24. List the average amount of time in group activities per week.
25. List the average amount of time in one on one activities per week.
26. Initiated activities: indicate the resident's initiation of activities.
27. Favorite activities: list the top three activities.
28. Services coordinated this month: check ALL services that were provided this assessment period.
29. Plan of Care:
    a. Indicate if current plan has been reviewed in the last quarter.
    b. Indicate if the plan is currently meeting the recipient's needs.
30. Date of the most recent review: enter the date of the last administrator and family authorization for placement.
31. Completed by: nurse signs and indicates title.
32. Date: enter the date the assessment was completed.
33. Fax the assessment to DMAS **by the 10th of the month** at 804-786-0206.